

Medical Directorate

18 May 2009

Our Ref: PL/TC/Iw

Mr Aiden O'Brien Urology Department CAH

Dear Aiden

I have now contacted and spoken to Mr Mark Fordham at length. I explained to him that we have patients who are being admitted for IV fluids and antibiotics. I gave him your viewpoint as best I could. He said that while he understood that you are doing your best for this group of patients, he did not know of any evidence base which would support these therapies.

We went on to a more detailed discussion about his practice and a widely accepted approach to recurrent urinary infections. He felt that once such patients had the initial standard investigations carried out, that they should be managed in primary care with no further hospital interventions. He talked about voiding techniques, advice to patients about oral hydration and the use of night time oral antibiotics. He also talked about the specifics in relation to females, and local oestrogen therapy and advising patients in relation to personal care. He also felt that if patients needed particular advice and reassurance that a once weekly MSSU provided at the hospital for 6 successive weeks would indicate that 90% of these patients did not have urinary infections and had what he described as "abacterial "cystitis.

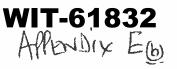
I explained that we have a very strong antibiotic guideline in place. He supported the use of such a guideline and went on to say that he believes that such circumstances need bacteriological evidence before antibiotics should be commenced.

Summary

Over the last 6 weeks, I have spoken and written to you about a cohort of about 30 patients who are admitted for IV antibiotics and IV fluids as a prophylaxis for recurrent UTI's.

We have had a letter from a politician asking for the treatment to be provided at home. Our CX is taking this forward with Mrs C Hanna, MLA.

Cont'd.



Page 2

I have discussed the situation with a senior microbiologist from Stoke Mandeville who believes there is no evidence base to support the treatments.

In the above paragraphs I have described the reaction of a senior urological surgeon from Manchester who also believes there is no evidence to support the treatment.

Our commissioner has expressed concern and asked me to seek independent advice so that an evidence based discussion could take place around the continuation or discontinuation of such therapies.

I would now like to meet with you immediately to take this forward. In advance of the meeting perhaps you could reflect on the possibility of changing these patients to oral therapy with an MSSU taken at the hospital at a regular interval. As on previous occasions, I have copied this to Michael Young, whose opinion on the way forward might also be valuable.

Dr Patrick Loughran Medical Director

cc Mr Michael Young, Consultant Mr Colm Donaghy, Chief Execurive

Southern Trust Headquarters, Craicayon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ

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/ Fax: Personal Information redacted by the USI

/ Email:



Medical Directorate

12 May 2009

Our Ref: PL/tc

Mr Aiden O'Brien Urology Department CAH

Dear Aiden

At our meeting on 21 April we discussed the cohort of patients who are elective admissions to receive IV fluids and antibiotics.

I have searched the NICE Guidelines for the current position on the prevention of recurrent UTI and have turned up clinical guidance for UTI in children – and therefore not relevant. The NICE guidance on Chronic Kidney Disease does not deal with infection.

I have contacted Dr Corrigan, on behalf of our commissioner. In the absence of NICE or other peer reviewed support for IV antibiotics and/or IV fluids, the commissioner would not support the provision of this at home. Dr Corrigan and I have therefore agreed that this Trust should immediately seek independent advice on how such patients are treated in other Trusts in N Ireland and other parts of the UK.

I have received a copy of the paper on the work you are doing in relation to this treatment. I have contacted Jean O'Driscoll who is a consultant microbiologist in the East of England who has carried out a literature search for me. This search did not show any evidence in support of intravenous fluids and IV antibiotics as a recognised prophylaxis,

I am awaiting a return call from Mr Mark Fordham who is a Consultant urologist in Manchester and who is very familiar with the NI urology service. I am hoping to ask for his independent views on the IV therapies.

Cont'd	
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APPENDIX F(b)

Page 2

I spoke to Mr Young on the afternoon of 21 April, as the lead clinician, to make him aware of the background to our meeting and the expectation of an Independent inspection of the IV therapy.

I will keep in touch by letter and telephone as required.

Yours sincerely



Dr Patrick Loughran Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Personal Information redacted by the USI Personal Information redacted by the USI



Medical Directorate

2 June 2009

Our Ref: PL/lw

Mr Aiden O'Brien Urology Department CAH

Dear Aiden

Thank you very much for meeting with me today. We agreed that you:

- would provide me with a complete list of the patients who are currently on the IV programme.
- will accept an independent assessment of this IV therapy.

I will arrange terms of reference with Mr Mark Fordham and speak to Jean O'Driscoll the Micro-biologist again.

I will also speak to Michael Young in due course.

Regards



Dr Patrick Loughran Medical Director

cc Mr Michael Young, Consultant Mr Colm Donaghy, Chief Executive

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel, Personal Information redacted by the USI





Medical Directorate

Memorandum

Our ref:	PL/Iw	Your ref:					
To:	Joy Youart, Acting Director for Acute Services						
c.c.	Mr Aiden O'Brier	n, Consultant, Urology Depar	rtment				
From:	Dr Patrick Lough	ran, Medical Director					
Date:	24 th June 2009						
Subject:	Urology patient	s on IV Therapy					

Dear Joy

I have spoken to Mr O'Brien who has agreed to have an independent assessment on the efficacy and appropriateness of IV Therapy. Within our discussions he agreed to send me the details of this group of patients so that we could extract appropriate information from their charts. He has not replied despite telephone and written reminders.

I would be grateful if you could identify a secretary or member of medical records staff who could help me. I look forward to your reply.

Regards



Dr Patrick Loughran Medical Director

APPENDIX I

Meeting re Urology Clinical Practice

Date: 4th August 2009

In attendance: Dr Patrick Loughran, Medical Director

Mr Aiden O'Brien, Consultant Urologist Mr Michael Young, Consulant Urologist

Previous positions re the treatment of the identified cohorts of patients discussed. Dr Loughran explained that the Trust had engaged two experts Mr Mark Fordham (Urologist) and Dr Jean O'Driscoll (Microbiologist) to provide an opinion on the efficacy of the present intravenous regimes. They would review the charts of a number of patients and current urology and microbiology practices.

After further explanation of each others positions the following was agreed:

- 1. A further meeting to take place in September
- 2. A meaningful active and accurate list of patient details to be provided by Friday 7th August by Mr O'Brien and Mr Young.
- 3. Each surgeon will personally review the current treatment regime for each patient on the list.
- 4. A multidisciplinary group would be convened to review the reduced list of patents and agree a treatment plan for each patient. This group would consist of microbiology and urology consultants.
- c.c. Dr Nazim Damani Mr Colm Donaghy

Update: 7th August 2009

Dr Loughran met with Dr Damani today. Dr Damani has agreed to be a member of the multidisciplinary team.

Wilson, Roberta

From:

Fordham Mark (RQ6) RLBUHT

Sent:

23 October 2009 11:47

To:

Wilson, Roberta2

Cc:

Loughran, Patrick

Subject: Mark Fordham - Royal Liverpool Hospital

Dear Roberta,

It was helpful to know about your background in rheumatology. I think you will have seen patients who can become dependant on a hospital team for their incurable but non fatal conditions.

As promised I have asked the opinion of 2 senior colleagues who are active in female, reconstructive and neuro-urology surgery.

Best wishes

Mark

My description of the cases is below with their comments.

My description of the situation:-

I have been asked to look at some cases done by another consultant working many miles from us.

He has a group of patients whose atonic bladders have been managed by a variety of surgical procedures eventually ending up with cystectomy and ileal conduit diversion.

Some of the patients have what sounds like pelvic pain syndrome too.

These patients seem to have a variety of on-going symptoms and a positive ileal conduit urine culture results in a diagnosis of UTI causing the symptoms.

The patients' management that I've been asked to comment on [by the hospital medical director] is:admitting the patient to hospital for 5 -7 days for i.v. fluids [one litre over 24 hours] together with 5 -7 days of i.v. antibiotics; being regularly repeated on a 2 or 3 monthly basis.

This is called 'rehydration and antibiotic therapy'.

My experience of this type of patient is that they can be rather 'heart-sink' individuals who have a normal life expectancy but have recurrent and various symptoms but once you have operated on them [especially cystectomy and ileal conduit formation] they are yours for the rest of your professional life.

However, I suspect that oral antibiotics either night-time trimethoprim or rotating antibiotics, a month at a time tend to be the most usual methods of trying to manage such cases....but I will be very happy to stand corrected by you.

First colleagues reply:-

Thank you for the e-mail. I would suggest that this is an idiosyncratic way of managing patients with persistent symptoms after urinary diversion. However, there is a group of patients with conduits (who have usually been diverted for benign rather than malignant disease) who have symptoms that are difficult or impossible to manage effectively. Most urologists who deal with this patient group would agree that these individuals are a significant drain on resources as a result of repeated investigations and unplanned admissions to hospital. It often ends up with a situation where one is excluding serious, treatable complications and then providing supportive care in conjunction with the primary care team. That support can take on different forms but may include planned or unplanned admission to hospital at different times. In summary, these patients are "high-maintenance" whatever you do.

I would suggest that there is no single right way for managing these peoples' symptoms. However, I would

30/12/2009

make the following comments:

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- 1. If there are clear clinical reasons for suspecting infection, then there is a case for taking a catheter specimen of urine from within the ileal conduit. Bag specimens of urine are unlikely to be of any value.
- 2. In the absence of clinical evidence of infection, conduit samples are likely to be misleading as asymptomatic bacteruria is very likely to be present in any patient with a conduit.
- 3. I would be uncomfortable with the implied idea that these patients are told they have a firm diagnosis (dehydration and infection) when that may be spurious. If their symptoms are not understood, then I feel they should be told that.
- 4. IV rehydration for someone who is drinking normally seems to be a nonsense.
- 5. IV antibiotics also seem to be inappropriate if alternative, oral agents can be used in adequate doses.
- 6. I agree that, if infection does clearly seem to be an issue (with good clinical justification for this) then most urologists would use chronic low-dose, rotating antibiotics or a several-weeks course of oral antibiotics at full dose
- 7. I sounds to me as if the clinician has used this system as a means of providing supportive care and keeping the patients "under control". I suspect that the main benefit to the patient will be psychological - being admitted to a supportive environment with support for their persistent belief that their symptoms have a physical basis - and who is to say that they might not be doing better than similar patients who do not receive this level of support? However, I would find it justify on the basis of scientific validity and standard clinical thinking.

Second colleagues reply:-

A lot depends on whether he took the bladder out. Recurrent pyocystis is a frequent long term problem especially in neuropaths if the bladder is left behind - I have rarely done a cystectomy and IC for an atonic bladder since most will tolerate ICSC pretty well. If the bladder were left behind in one of these patients recurrent pyocystis would be inevitable. Rehydration (not sure 1 litre in 24 hours really qualifies) and antibiotics would not help much -- frequent bladder washouts might but usually these patients end up with a salvage "simple" cystectomy later on

The UTIs are interesting – are these simply positive cultures from the conduit (which is usual as you know) or are they symptomatic infections? If the bladder was indeed removed then I doubt that one could attribute a chronic pelvic pain syndrome to recurrent UTI even if it were symptomatic

Like you I would usually manage recurrent symptomatic UTI in a conduit patient with rotating low dose antibiotics.

On balance the management strategy you describe sounds to have been a little unusual

Appenoix K

Wilson, Roberta

From:

Fordham Mark (RQ6) RLBUHT

Sent:

10 October 2009 14:52

To:

Wilson, Roberta2

Subject: Mark Fordham - Royal Liverpool Hospital

Dear Roberta,

Apologies for the delay in sending you my comments of cases 3,4,6,7 and 8.

All these patients have a diagnosis of a functionally abnormal bladder and all but one has undergone major surgery and all but one has had the bladder removed.

Two of the patients also seem to have symptoms of a pelvic pain syndrome.

These combinations add up to 'heart sink' patients where in all probability there is no 'cure' available and they become chronic hospital attenders with various and variable symptoms sometimes resulting in numerous investigations generally with little in the way of positive diagnoses.

Because they have a functional problem the patients have a normal life expectancy and so will remain on the consultants books for decades.

The condition they have may be relatively uncommon [low incidence] but they live for many years and can require repeated consultations [high prevalence].

This can lead to the patients becoming hospital-dependant/institutionalised with the GP being disinclined to get involved as the case is 'complex' ie they do not know what to do.

Whether these patients have been well served by the major bladder surgery they have undergone is difficult to say as the records do not include the original letters leading up to the surgery.

The current clinical challenge is how to look after patients with ileal conduit diversions performed for functional disease and who suffer from recurrent symptoms which may or may not be related to urine infections.

Quite often a 'modus operandi' develops which 'works' for an individual patient.

This allows the doctor to feel he is doing something therapeutically effective and the patient feels something is being done; although what action is taken will vary between hospitals and consultants.

To my knowledge there is no standard treatment regime for recurrent urinary infections in patient with ileal conduits, although the mainstay of management is oral antibiotic therapy. However I will ask my colleagues in BAUS who do specialise in these pathologies and see how they manage

such patients and see if there is a consensus.

I'll let you know when I have heard from them

With all good wishes

Mark

Royal Liverpool Hospital

L7 8XP

30/12/2009

APPENDIX L

Key points from discussions with Dr Mark Fordham

Date 02 12 09

- 1 The management of these patients can be challenging.
- 2 They have normal life expectancy (non cancer patients)
- They can become psychologically dependent on hospital services even in the absence of specific clinical needs.
- 4 Clinically diagnosed urinary tract infections are best confirmed by laboratory urine cultures but urine cultures from bowel based urine reservoirs or conduits need to be interpreted with care.
- The local urology regimes for these patients do not have a scientific evidence base.
- There is no need to treat patients with IV fluids who are able to drink normally.
- 7 The use of IV antibiotics should be reserved for patients with multiresistant urinary infections or severe pyelonephritis
- 8 Care can be provided with the support of primary care using various treatments relating to out patient oral antibiotic regimes.
- These patients sometimes require unplanned admission when acutely unwell.

Appendix M

Wilson, Roberta

From:

Wilson, Roberta

Sent:

02 December 2009 17:52

To:

'Fordham Mark (RQ6) RLBUHT'

Cc:

'Loughran, Patrick'

Subject:

RE: Mark Fordham - Royal Liverpool Hospital

Attachments: Key points from discussions with Dr Mark Fordham.doc

Mark

Thank you for contacting me. Amendments as discussed. Also in a word document if formatting difficult to read.

- 1 These cohorts of patients are difficult to manage
- 2 They have normal life expectancy (non cancer patients)
- 3 They can become psychologically dependent on hospital services in the absence of clinical need for services.
- 4 Proven UTIs may be best managed with Antibiotics. Where no pure growth is identified or urine cultures are from bowel based urine reservoirs, urine sampling needs to be interpreted with care.
- 5 Their current regimes do not have a scientific evidence base.
- 6 There is no need to treat patients who are able to drink normally with IV fluids
- 7 There are other more appropriate antibiotic regimes available.
- 6 Care can be provided with the support of primary care using various other treatments relating to out patient antibiotic regimes.
- They will require unplanned admissions at different times for different reasons and proven indications including acute episodes of urology care

Regards

Roberta Wilson
Governance Lead Medical Directorate
First floor
Nursing Home
Daisy Hill Hospital
Southern Health and Social Services Trust
Tel. DHH extn | Personal Information redacted by the USI |

Diane Corrigan

From: Diane Corrigan

Sent: 19 August 2010 18:17

To:

Carolyn.Harper reduced by the USI
Personal Information
Personal Information
reduced by the USI
Personal Information
reduced by the USI

Cc: libby.jones redacted by the USI

Subject: Important - advice needed on issues relating to clinical practice in Urology **Attachments:** NI cystecomy and ileal conduit creation stats 200506 to 200910.xls; draft SHSCT

report on IVT in urology Jan 10.pdf

Dear all

I have cut and pasted in some emails below which I hope are self-explanatory. There are also some attachments. In summary, in April 2009 I was approached by Dr P Loughran, the Medical Director of SHSCT, to seek my views as a commissioner of services as to whether a particular treatment being undertaken by Urologists in CAH was appropriate. This was regular elective admission of a small cohort of patients with chronic urinary tract infections to have IV fluids and antibiotics. The patients concerned believe that this 'flushes them out' and appear to value the treatment. I thought it was biologically implausible for this form of treatment to be any more effective than oral treatment. This view concurred with opinions Dr Loughran had already garnered from clinical colleagues. Although this treatment was wasteful of resources, it did not appear at that time to pose a clinical risk to patients. I gave Dr Loughran some advice on how to deal with the issue, including a contact for an external urology opinion.

I was next involved in January 2010 when Dr Loughran approached me to say that although he had agreed with the clinicians that the treatments would be phased out this had not in fact happened. He had prepared a paper for the Trust's SMT and as it referred to me he sought my opinion on the wording of the relevant paragraph. I suggested amendments (which you will see below), but did not see a final version of the report. The report's Appendices (see PDF attachment) included comments from external urologists which concurred that the treatment was not in keeping with practice elsewhere in GB.

At a recent meeting with the Trust about the Urology Review it emerged that not only had the treatment not yet stopped, but some patients (possibly 2) were now receiving this treatment via a central line. Given the risk that having an indwelling line poses to patients I felt that I needed to take this further. I emailed Mr Eamon Mackle, Clinical Director of Surgery at the Trust (see below) who indicated that the Medical Director had now asked him to deal with the issue. On the day I spoke to him he did not appear to be aware that I had provided previous comments, hence the purpose of copying him information on the timeline and the draft report. I re-read the report and began to wonder if there was something unusual about the cohort of patients. One of the external opinions referenced the fact that several of the patients had ileal conduits. I imagined that the prevalent population of patients with ileal conduits in the CAH catchment would not have been very large. To put my mind at rest I asked for some information on the numbers of such operations done over the last 5 years in NI by consultant. This is attached above in an Excel spreadsheet. There are all sorts of caveats in interpreting this data, depending as it does on coding quality and completeness. However the raw data show that of 185 cases over the period, 170 had a diagnostic code which indicated malignancy or carcinoma in situ. Another 2 were coded as 'neoplasm uncertain'. Three were done by a single urologist in BCH for neurological disorders. Of the remaining 10 which did not have those diagnoses, six were done by a single consultant at CAH. Four had a primary diagnosis of cystitis, one had a diagnosis of faecal incontinence and one of peritonitis.

I have tried to think of possible data-related explanation for this. If there was very poor coding practice in a hospital then maybe a patient who had a longstanding ileal conduit, admitted for treatment of cystitis might, in theory at least, be coded as though they had the cystectomy and ileal conduit as elective operations each time - but if so that coding error would need to be highlighted and stopped. However if there really is an underlying issue - what is the role of the PHA in drawing this to the Trust's attention?

I have included draft wording of an email which I was considering sending to the Medical Director, Director of Acute Services and Clinical Director of Surgery at SHSCT. However I thought that before doing so I needed guidance on whether this was the correct way to deal with this issue.

I would be very grateful for your comments and advice on the following points

- (i) Do you agree that the line I had already taken on the use of regular IV fluids and antibiotics for chronic cystitis was correct?
- (ii) Do you agree that continuing this form of treatment in the light of external advice from external urologists calls for further action, especially since some of patients now appear to have had central lines inserted for the purpose?
- (iii) Do you think that the statistics on cystectomy and ileal conduit creation by one consultant at CAH are sufficiently different from the pattern of treatment in other units for me to raise this with the Trust? The numbers are small and all of the information from each Trust is subject to the quality of their coding.
- (iv) Do you think my comment in the draft email seeking assurance that, following the Urology Review, no further radical pelvic surgery should now be happening in CAH is appropriate?

Regards

Diane

COPY OF EMAIL TO CLIN DIR OF SURGERY AT SHSCT

-----Original Message-----From: Diane Corrigan

Sent: 09 August 2010 13:12

To: 'eamon.mackle

Subject: FW: Intravenous Fluid & Antibiotic Therapy (IVT)

Importance: High

Dear Eamon

Re our discussion at the end of the Urology meeting - I found this email and thought I should forward it to you. You may by now have had sight of the Trust's full internal file on this issue.

My timeline for events relating to this issue is:

21 April 2009 - phone discussion with Dr Loughran in which he indicated that a cohort of patients having this IV treatment had come to light when implementing the Trust's new antibiotic prescribing policy. I advised involvement of the CD and if necessary external advice from Mark Fordham. I emailed Mark's address on the 22nd April.

Paddy called me again on the 4th Jan 2010 to say that although the clinicians had agreed to change practice, it had emerged that this had not happened. He planned to prepare a paper setting out the issue for discussion (? within Trust management). He forwarded a draft to me (attached) and the email below was my response. I do not think I ever saw the final report which was for internal use in the Trust. The draft paper indicated that insertion of central lines to deliver this therapy was being considered for two patients. From your comments it sounds as though this has actually gone ahead. I am very concerned as to how this could have happened. It is a matter for the Trust to decide, but I think the latter begins to sound like an SAI.

I have re-read the Appendices to the draft report. Perhaps I am reading more into them than was meant - however am I right in thinking that almost all of these patients have had cystectomy and ileal conduits for benign disease? I would have imagined this would have been a treatment of last resort. Is there any possibility that there is a wider issue here - i.e. not just the continued use of a non evidence-based treatment for UTI, but a higher than expected use of radical surgery for the underlying pathology? As a first step maybe I can ask our information department to see whether it is possible to extract information on the number of cystectomies done in NI for benign disease over the last decade. This will depend on the coding quality - however if it shows nothing untoward in terms of numbers done at CAH then concentration on IVT would remain the most pressing issue.

This could be very difficult. I would advise a team approach within the Trust - involving the Medical Director and the Dir of Acute Services - dealing with this on your own would not be a good idea.

Please let me know if there is anything else I could do.

Diane

EXTRACT OF EMAIL TO MEDICAL DIR SECRETARY

----Original Message----From: Diane Corrigan Sent: 06 January 2010 16:13

To: 'White, Laura'; Paddy Loughran

Cc: Wilson, Roberta

Subject: RE: Intravenous Fluid & Antibiotic Therapy (IVT)

Thank you for letting me see this draft report. I have two comments.

Firstly, since I am now an employee of the PHA, I'm not sure it is technically correct to call me the 'commissioner' anymore - though the best alternative I can come up with is 'PHA adviser to the HSCB Southern office' which is very longwinded. With that in mind could I suggest that page 3 para g is amended to read

"I have discussed the above with Dr D Corrigan, the PHA adviser to the HSCB Southern office. On the basis of the information provided, she has advised that it would not be appropriate for SHSCT to continue to provide a treatment for which there is neither a published evidence base, nor a supporting consensus of professional opinion outwith the Trust. If SHSCT urologists feel strongly that this treatment is of value they should participate in a recognised clinical trial, with ethical committee approval. For those patients already on this treatment regimen an orderly process should be agreed and implemented to move them onto alternative treatment regimes, with the support of medical microbiology. It will be important that the reasoning behind this decision is sensitively communicated to this cohort of patients."

I also think the patient names should be removed from the Appendix (Carmel Hanna's letter) as the report may end up being copied and this could lead to a breach of patient confidentiality.

Regards

Diane

----Original Message----

From: White, Laura

Sent: 05 January 2010 14:19

To: Corrigan, Diane Cc: Wilson, Roberta

Subject: Intravenous Fluid & Antibiotic Therapy (IVT)

Dr Corrigan

Enclosed as per your telephone call with Dr Loughran, you are mentioned under Page 2, No 6 and Page 3, "G".

Laura

Ms Laura White
Personal Assistant to
Dr Patrick Loughran
Medical Director
Southern Health & Social Care Trust

DRAFT EMAIL TO SHSCT 19 AUG 2010 VERSION

Dear

In the context of the Urology Review implementation process, which highlighted a high proportion of elective urology episodes which did not have an operative procedure, I re-read the external expert reports relating to the use of IV therapies at CAH (Appendices of the draft document I was asked to comment on last January). I picked up on a comment that many of the cases had ileal conduits. I emailed Eamon Mackle a few weeks ago to the effect that just to put my mind at rest I intended to seek NI-wide information on the numbers of cystectomies and ileal conduits carried out by Unit and consultant.

I enclose the results. These have to be interpreted with caution as they are dependent on coding quality. In addition I appreciate that the numbers are very small. It appears that cystectomy and conduit creation is done in the great majority of cases for malignant disease. However there appear to be small numbers done for other reasons. Four of the operations coded as being done by one of the CAH surgeons were for cystitis. This would appear to be unusual. Is there any possibility that this reflects incorrect coding and in fact these are multiple admissions of patients who have had the procedure in the past and who have been admitted for other reasons?

Following the Urology Review decision, as of March 2010 radical pelvic urology surgery for malignant disease should no longer be being done in SHSCT. This would include cystectomy. We have discussed the cancer cases recently at the meeting chaired by Beth Malloy from PMSI at the HSCB. The rationale for this policy decision, which is in line with IOG guidance, was to concentrate the relatively small number of such cases in the hands of a small number of surgeons who could maintain specialist skills. No reference was made in the Urology Review to radical pelvic surgery for non-malignant diseases. It was perhaps assumed to be implicit that the even smaller volume of this type of work would also be centralised. I would be grateful for an assurance that the urology team is now referring on all patients being considered for radical pelvic surgery regardless of the underlying diagnosis.

Best	14/10	hac
nesi	WIN	1167

Diane

Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10

WIT-6184

MARY YORK	Hospital Description	Consultant Name	Primary Operation	Contation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	ir Olegnostic Bescription	Elective FCE's
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		Mulholland C.K Mr	M34 1	Total Excision Of Bladder - Cystoprostatectumy	M19.1	Utimary Diversion - Construction Of Iteal Conduit	C67.9	Malignani Neoglasm Of Bladder, Unspecified	1
- 9	Altnagelvin Hospital			A. T. C.	0.0000000	W-100-11 - 1-10-1-10-1-10-1-10-1-10-1-10		Total	
1	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	Disgradis Description	Elective FCE's
- 3	Belfast City Pospilal	Hegan C Mr	M19.1	Unitary Diversion - Construction Of Iteel Conduit	M34 3	Total Excision Of Stadder - Cystectomy Nec	C67.9	Matignant Neoplasm Of Bladder Unspecified	1
		Hagen C Mr	M34.1	Total Excision Of Bledder - Cystoprostatechney	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoglasm Of Bladder Unspecified	111
- 8		Hagen C Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19.1	Grinary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoglasm Of Bladder, Unspecified	1
- 1		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystertomy Nec	M19.1	Utinety Diversion - Construction Of Ileal Conduit	C67.9	Malignent Neoplesm Of Bladder, Linearched	1
- 3		Hagsin C Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19.1	Orinary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hegan C Mr	M34.3	Total Excision Of Bladder - Dyslectomy Nec	M19.1	University Diversion - Construction Of Itaal Conduit	C67.9	Makgrant Neoplasm Of Bladder, Unspecified	1
- 3		Hegen C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Ultimary Diversion - Construction Of Ileal Conduit	C67.9	Makgnant Neoplasm Of Bladder, Unspecified	1
- 8		Hagsin C Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C66.X	Maignant Neoplasm Of Urelor	1
- 3		Keene PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 2	Unnury Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Malignant Neoplasm Of Bladder Linspecified	1
3		Keene PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatecromy	M19.2	Uninery Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Melignant Neoglasm Of Bladder, Unspecified	1
05/2006		Keens PF Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19.1	Uning y Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoglasson Of Bladder, Linspecified	1
- 8		Keane PF Mr	M34.3	Total Excision Of Bledder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoglasim Of Bladder Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19.1	Unitary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Necessary Of Bladder, Unapported	1
- 3		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostalectomy	M19.1	Ultimary Diversion - Construction Of Ileal Conduit	C67 9	Matignant Neoglasm Of Bladder Unspecified	1
- 1	Belfast City Hospital							Total	.14
9	Hospital Description	Consultant Name	Frimary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	n Diagnostic Description	Elective FCE
9	Causeway Hospital	Kernohen R M Mr	M34.3	Total Excision Of Bledder - Cystectomy Nec	M19.1	Utiniary Diversion - Construction Of Iteal Conduit	N30.9	Cystrin, Unspecified	1
- 3	Causeway Hospital							Total	1
- 8	Hospital Description	Consultani Name	Primary Operation	Operation Description	Secondary Operation Code	Secundary Operation Description	Primary Diagnos	in Diagnostic Description	Elective FCE
- 3	Creigayon Area Hospital	O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystactomy Nec	M19.1	Urmany Diversion - Construction Of Ileal Conduit	N00.2	Other Chronic Cystitis	1
- 8	Management of the second	Young M Mr	M34.1	Total Excision Of Stedder - Cysthorostatectomy	M19.1	Unitary Diversion - Construction Of Iteal Conduit	C87.9	Matignant Neoplasm Of Bladder, Linspecified	1
- 7	Craigavon Area Hospital							Total	2
3	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	ii Diagnostic Description	Elective FCE
	Mater Hospital Has Trust	Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Unitary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Respissm Of Bladder, Unspecified	1
- 8		Wilson BG Mr	M34 1	Total Excision Of Bladder - Dystopromatactomy	M19 T	Diversion - Construction Of Ileal Conduit	C61 X	Malagrant recopiesm Of Prostate	1
	Mater Hospital Has Trust							Total	2
05/2006			200			# -use-		Total FY2005/06	21



scal Year Ho	ospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primery Diagnos	r Chagnestic Description	Elective FCE's
All	Inagelvin Hospital	Mulholland C.K.Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	604.1	Total Excision Of Bladder - Cystee ostatectomy	C66 X	Malignant Neoplasm Of Ureter	1
		Mulholland C.K Mr	M34.1	Total Excision Of Bladder - Cystopiasta tectony	M19.1	Unitary Diversion - Construction Of finel Conduit	C67 9	Mongnant Neoptesm Of Bladder, Unspecified	1
		Mulholland C.K.Mr	M34 2	Total Excision Of Bladder - Cystinus Investigation	609.1	Unitally Diversion - Construction Of Iteal Conduit	C67 2	Marignant Neoptasm Of Lateral Wall Of Bladder	1
Alt	tnagelvin Hospital					1 00000		Total	3
Mic	ospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnas	le Diagnostic Description	Electree FCE
Be	olfast City Hospital	Hagan C Mr	M34.3	Total Excesion Of Bladder - Cysterning Nec	M19 1	Univery Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hegen C Mr	M34.3	Total Excision Of Bladder - Cyttle army Nec	M19 1	Urrary Diversion - Construction Of Iteal Conduit	C67 9	Make nent Neoplasm Of Bladder, Unaperfied	1
- 1		Hagen C Mr	M34.3	Total Excision Of Bladder - Cytaic only Nec	M19 t	Urinary Diversion - Construction Of Iteal Conduit	C67 9	Malignani Neoplesm Of Bladder, Unspecified	1
0		Keane PF Mr	M34.1	Total Excision Of Bledder - Cystopicatalisc formy	M19 1	Diversion - Construction Of fleat Conduit	C67 9	Malignant Neoplasm Of Bledder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cyster Dirty Nec	M19 1	Unintry Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplesm Of Bladder, Unaper died	1
		Keane PF Mr	M34 1	Total Excision Of Bladder - Cyalogi ostalectomy	M19.1	Diversion - Construction Of Heal Conduit	C67 9	Malignant Neoplesm Of Bladder, Unapeched	1
3	1000	Keane PF Mr	M34 1	Total Excision Of Bladder - Cystopi ostatectomy	M19 1	Unitary Diversion - Construction Of fleet Conduit	C67.9	Maliginant Neoprasin Of Bladder, Unspecified	1
		Keane PF Mr	M34 3	Total Excision Of Bladder - Cylviectomy Nec	M19.1	Unitary Diversion - Construction Of Beel Conduit	C67 9	Malignant Neopie sm Of Bladder, Unspecified	1.
100		Keane PF Mr	M34.3	Total Excision Of Bladder - Optilisationy, Nec	M19.1	unsitery Diversion - Construction Of fleel Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
100		Keane PF Mr	M34.1	Total Excision Of Bladder - Cysloprosta tectomy	M19 2	University Diversion - Creation Of University Diversion To Intestine Nec	C67.9	Malignant Neopig sm Ol Bladder, Unspecified	1
25	01/	Rage TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectorry	M19 1	Ulmary Diversion - Construction Of Iteal Conduit	C67.9	Maky nant Neopiesm Of Bladder Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystop ostatectomy	M19 1	Urmany Diversion - Construction Of Ileal Conduit	C67 9	Mislig nant Neoplesm Of Bladder, Unspecified	1
3	5	Raien TN Mr	M34.1	Total Excision Of Bladder - Cymoprostatectomy	M19 1	Diversion - Construction Of Illeel Conduit	C67 9	Malignant Megissum Of Bladder, Unapacting	1
006/2007		Raien TN Mr	M34.1	Total Excision Of Bladder - Cylindr ostalactomy	M19 3	United y Diversion - Revision Of United y Diversion	C67.9	Malignant Neopia sm Of Bladder, Unspecified	
006/200/		Raum TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatecomy	M19 1	Ur may Diversion - Construction Of Ileal Conduit	C66.X	Make nant Neophis - Of Ureter	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cymioprostalectomy	M19 1	Urina's Diversion - Construction Of Ileal Conduit	C67.9	Natignant Neopissmi Of Bladder, Unspecified	1
		Rause TN Mr	M34.1	Total Excision Of Bladder - Cyproproplatectomy	M19 1	Urmary Diversion - Construction Of Ileal Conduit	C67.9	Makig nant Neople sm Of Bladder, Unspecified	1
Be	elfast City Hospital							Total	17
#4	cepital Description	Consultant Name	Primary Operation	- Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	in Diagnostic Description	Elective FCE
Cr	raigavon Area Hospital	Batstone GRD Mr	M34.3	Total Excision Of Bladder - Cyphectorny Nec	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malgnant Neograsm Of Stadder, Unspecified	1
		Batstone GRD Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neopiasm Of Stadder, Unspecified	V
		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cys oprostar actomy	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	,
		O'Brian A Mr	M34.1	Total Excision Of Bladder - Cystogrostate formy	M19 1	Urinary Diversion - Construction Of Real Conduit	C67 9	Malignant Neoglasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cyslectumy Nec	M19.1	Livesia Diversion - Construction Of Heal Conduit	C67 9	Malignani Neoplasm Of Bledder, Unspecified	
		O'Brien A Mr	M34.3	Total Excision Of Stadder - Cysted only Nec	M19.1	Urnary Diversion - Construction Of Ileal Conduit	N30.1	Interstitial Century Chronic	,
-		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cyster one Nec	M19.1	Urinary Diversion - Construction Of Real Conduit	N30.1	Interstitial Cysters (Chronic	1
	58.7	Young M Mr	M34.1	Total Excision Of Bladder - Cystop ostatectoms	M19.1	Livrally Diversion - Construction Of Heat Conduit	C67 9	Metignani Neoplasm Of Bladder, Unspecified	1
Cr	ralgavon Area Hospital							Total	8
100	capital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	in Dispressic Description	Elective FCE
M	later Hospital Has Trust	Wilson BG Mr	M19.1	Unitary Diversion - Construction Of Iteal Conduit	M34 1	Total Excision Of Bladder - Cystoprostatectomy	067.9	Make nent feedblasm Of Bladder, Unspecified	1
		Wilson BG Mr	M19 1	University Diversion - Construction Of Iteal Conduit	M34 Y	Total Excision Of Bladder - Cyslographatectory	C67.9	Many nant Neoplasm Of Bladder, Unspecified	1
	- 3	Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystopi ostalectome	M19 1	Ulmary Diversion - Construction Of Ileal Conduit	067.9	Mangnant Neopteam Of Bladder, Unspecified	1
	later Hospital Has Trust	The second					1 33	Total	3
006/2007				_		-		Total FY2006/07	31

al Year	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	ii Diagnostic Description	Elective FCE
- 8	Befast City Hospital	Hagan C Mr	M19.2	Uninary Diversion - Creation Of Uninary Diversion To Intestine Nec	M34 3	Total Excision Of Bladder - Cystactomy Nec	C67.9	Malignant Neoplasm Of Bladder, Linspecified	1
		Hagan C Mr	M34 3	Total Excision Of Bladder - Cysteutomy Nec	M19 1	Ulmary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder Unspecified	1
- 3		Hagan C Mr	M34.3	Yotal Excision Of Bledder - Cyslectomy Nec	M19.1	University Diversion - Construction Of Iteal Conduit	C67.9	Maignant Neoplasm Of Bladder, Unspecified	1
- 3		Hagan C Mr	M34.1	Total Excision Of Bledder - Cystoprostatectoms	M19.1	University Diversion - Construction Of Ileal Conduit	C67.9	Melignent Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatestomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectumy	M19.1	Unnery Diversion - Construction Of Ileas Conduit	C61.X	Maignant Neoplasm Of Prostate	1
		Keene PF Mr	M34.1	Total Excision Of Bladder - Cystoprostale formy	M19 1	Ulmary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
- 3		Keane PF Mr	M34.3	Total Excision Of Bledder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	N32 8	Other Specified Disorders Of Bladder	1
		Keane PF Mr	M34.9	Total Excision Of Bladder - Unspecified	M19 1	Usinary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
- 3		Keane PF Mr	M34.1	Total Excision Of Bladder - Cymoprostar esterny	M19 1	Uninary Diversion - Construction Of Ileal Conduit	C67.9	Matignani Neoplasm Of Bladder Unspecified	1
		Keane PF Mr	M34.9	Total Excision Of Bledder - Unspecified	M19 1	University Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder Unspecified	1
- 9		Keene PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Unnary Diversion - Construction Of Ileal Conduit	C67.9	Malignani Neoplasm Of Bladder, Unspecified	1
	-0.000	Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	U-mary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder Unspecified	1
3		Rainn TN Mr	M34.1	Total Excision Of Bladder - Cymoprostalaciomy	M19 1	Uninary Diversion - Construction Of Ileal Conduit	C67.9	Malignani Neoplasm Of Bladder Unspecified	1
- 3		Rain TN Mr	M34 1	Total Excision Of Bladder - Cystoprestalactomy	M19 1	Ulmary Diversion - Construction Of Iteal Conduit	C67 9	Malignani Neoplasm Of Bladder, Unspecified	1
- 3		Rajan TN Mr	M34.2	Total Excision Of Bladder - Cyslour ethrecisms	M19 1	Uneary Diversion - Construction Of Real Conduit	C67.9	Malignam Neoplasm Of Bladder, Unspecified	1
		Rain TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Union Diversion - Construction Of Real Conduit	C67 9	Malignant Neoplasm Of Bladder, Unapacified	1
		Rainn TN Mr	M34 1	Total Excision Of Bladder - Cymoprosta ectomy	M19 1	Univery Diversion - Construction Of Iteal Conduit	Ç67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Raun TN Mr	M34.1	Total Excision Of Bladder - Cyaloprostalectomy	M19.1	Unitary Diversion - Construction Of Heal Conduit	C67.9	Maignant Neoplasm Of Bladder Unspecified	1
- 1		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Ulwary Diversion - Construction Of Beal Conduit	C87 9	Malignant Neoplasm Of Bladder Unspecified	
/2008		Rain TN Mr	M34.1	Total Excision Of Bladder - Cystoprosta e flomy	M19 1	Univery Diversion - Construction Of Ileal Conduit	D09.0	Carcinoma In Situ Of Bladder	
/2008		Rainn TN Mr	M343	Total Excision Of Bledder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Iteal Conduit	D09 0	Carcinoma In Situ Of Bladder	1
- 9		Rain TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Uniary Diversion - Construction Of Iteal Conduit	C67 9	Mangnam Neoplasm Of Bladder, Unspecified	1
		Rainn TN Mr	M34.1	Total Excision Of Bladder - Cystoprostate formy	M19 1	Univery Diversion - Construction Of Iteal Conduit	C61.X	Malamant Neoples Of Prostate	1
- 3		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urnary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Raion TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Utwary Diversion - Construction Of Real Conduit	C67 9	Matignant Neoplasm Of Bladder, Unspecified	1
- 3	Belfast City Hospital		714.74					Total	26
- 3	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	is Diagnostic Description	Elective f
- 9	Craigavon Area Hospital	Batstone GRD Mr	M34.1	Total Excision Of Bladder - Cystoprestatectomy	M19 1	Urinary Diversion - Construction of Item Conduit	C67.9	Malignant Neopleam Of Stadder Unspecified	1
		Mceltister C Dr	M34.1	Total Excision Of Bladder - Cystoprestatectomy	M19.1	Unitary Diversion - Construction Of Heat Conduit	C67.9	Malignant Neopress Of Stadder, Unspecified	1
- 3		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Unitary Diversion - Construction Of Heat Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cysloprostatectomy	M19.1	University Diversion - Construction Of leaf Conduit	C67 9	Malignant Neopleam Of Stadder, Unspecified	10
- 3		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urisary Diversion - Construction Of Ileas Conduit	¢67.9	Malignant Neoplesm Of Bladder, Unspecified	1
- 3	22	O'Brien A Mr	M34.5	Total Excision Of Bladder - Cystactomy Nec	M19.1	Uninary Diversion - Construction Of Heat Conduit	R15 X	Faecal Incontinence	1
		Young M Mr	M34.3	Total Excision Of Bladder - Cysterlowny Nec	M19.1	Urinary Diversion - Construction Of Heat Conduit	D41.4	Neoplaim Uncert / Unkn Behav Bledder	1
- 3		Young M Mr	M34.1	Total Excision Of Bladder - Cysloprostatectomy	M19.1	Uninery Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplesm Of Bladder, Unspecified	1
	Craigavon Area Hospital		5					Total	8
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnos	ir Diagnostic Description	Elective F
- 8	Mater Hospital Has Trust	Wilson BG Mr	M34 1	Total Excision Of Blassier - Cystoprostatectomy	M19.1	Unitary Diversion - Construction Of Item Consul	C87.9	Malignant Neoplesm Of Bladder, Unspecified	,
- 3		Witson BG Mr	M19.1	Utinary Diversion - Construction Of Ileal Conduit	MO4.1	Total Excision Of Bladder - Cystogrostatectomy	C87.9	Malignant Neoplesm Of Bladder, Unspecified	1
-		Witson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of fleel Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1



iscal Year H	ospital Description	Consultant Name	Primary Operation	Operation Description	Secondary Operation Code	Secondary Operation Description	Primary Diagnost	Diagnostic Description	Elective FCE's
Be	alfast City Hospital	Duggan B Mr	M34 3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Real Conduit	N31.2	Flacoid Neuropeine Bladder. Not Elsewhere Classified	1
		Duggan B Mr	M34 8	Total Excision Of Bladder - Other Specified	M19.1	Urinary Diversion - Construction Of Iteal Conduit	N31 9	Neuromuscular Dysfunction Of Bladder, Unspecified	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.7	Malignant Neoplasm Of Urachus	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder. Unspecified	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Heal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1.
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of fleat Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.1	Total Excision Of Bledder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of fleat Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	-	Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Ball Conduit	C67.≆	Malignant Neoptesm Of Bladder, Unspecified	1
		Hegen C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction of Iteal Conduit	N30 9	Eystitis, Unspecified	1
		Hagan C Mr	M34 B	Total Excision Of Bladder - Other Specified	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C61.X	Malignant Neoplasm Of Prostate	1
	-	Keene PF Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C61 X	Malignent Neoplasm 01 Prostate	1
		Keane PF Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Boal Conduit	C67 #	Malignant Neoplasm Q1 Bladder, Unspecified	1
-		Keane PF Mr	M34 3	Total Excision Of Bladder - Cystop distatectomy	M19.1	Urinary Diversion - Construction Of Real Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keene PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urnary Diversion - Construction Of fleet Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	
		Keene PF Mr	M34.3		M19 1	Urinary Diversion - Construction Of fleat Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	-
-		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1		C67.9		1
—		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of fleat Conduit Urinary Diversion - Construction Of fleat Conduit	C67 5	Malignant Neoplasm Of Bladder, Unspecified	
-		Keene PF Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit Urinary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder Neck Malignant Neoplasm Of Bladder, Unspecified	1
-		1	M34.1	Total Excision Of Bladder - Cystoprostatectomy			C67 9		
-		Keane PF Mr		Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Iteal Conduit		Malignent Neoplasm Of Bladder, Unspecified	
-		Keane PF Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M191	Urinary Diversion - Construction Of fleel Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
-		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Q1 Bladder, Unspecified	1
-		Rejen TN Mr	M34,1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67 9	Malignerst Neoplesm Of Bledder, Unspecified	
-		Rajan TN Mr	M34.1	Total Excision Of Bledder - Cystoprostatectomy	M19.1	Utinary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	
-		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
-		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	11
		Rajan TN Mr	M34_1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1,
2008/2009		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
L		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	
		Rejen TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinery Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit	D09.0	Carcinoma In Situ Of Bladder	1
L		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Itaal Conduit	D41.4	Neoplasm Uncert / Unkn Behav Bladder	1.
		Rajan TN Mr	M34.1	Total Excision Of Bledder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	. 1
Г		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Unnary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	D09.0	Carcinoma In Situ Of Bladder	1
		Rajan TN Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.5	Malignant Neoplasm Of Bladder Neck	1
		Rajan TN Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urmary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Ileas Conduct	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cystopiostatectomy Total Excision Of Bladder - Cystociomy Nec	M19 1	Urinery Diversion - Construction Of fleet Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
B4	elfast City Hospital	regan rivew	M34.3	Total Excision of Bradder - Cystectomy Nec	IWI5.I	Contain Contraction of lieux Controls	Cor.e	Total	42
		Consultant Name	Brimany Garantian	Operation Description	Connection Code	Secondary Operation Description	Brimani Diagnosii	Diagnostic Description	Elective FCE's
	ospital Description	O'Brien A Mr	M19.1		M19.2		C67.9		Elective FCE
100	raigavon Area Hospital			Urinary Diversion - Construction Of Ileal Conduit	M19.1	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
-		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	
\vdash	_	O'Brien A Mr	M34_1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Ileaf Conduit	1	Malignant Neoplasm Of Bladder, Unspecified	
\vdash		O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
\vdash	_	O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nac	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34 3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Iteal Conduit	R32.X	Unspecified Urinary Incontinence	1
L		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	N30_1	Interstitial Cystitis (Chronic)	1
_		Young M Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C61.X	Malignant Neoplasm Of Prostate	1
L		Young M Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19 1	Urinary Diversion - Construction Of Ileal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
L		Young M Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	M19.1	Urinary Diversion - Construction Qf Ileal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
Cı	raigavon Area Hospital							Total	10
008/2009				1	1		1	Total FY2008/09	52

WIT CAREA

44

Total FY2009/10

Elective FCE's 1 1 1 1 1 1 1 1 1
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Source: PAS DSS Admission & Discharges Universe Produced by: Information Services SO HSCB Ref: Q1026 - Run Date: 17/08/10

FY2009/2010

Notes - Primary & Secondary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2



Diane Corrigan

From:

Diane Corrigan

Sent:

26 August 2010 10:27

Donnelly, Jeanette

To: Subject:

RE: Cystectomy information

I'm going ahead to write to the Trust on the basis of what we already have - but ideally within 2 weeks?

Diane

----Original Message----

From: Donnelly, Jeanette

Sent: 26 August 2010 10:00

To: Corrigan, Diane

Subject: RE: Cystectomy information

"This e-mail is covered by the disclaimer found at the end of the message."

If we require info for previous years we need to request it from BSO, I will contact Michelle Bell in BSO (Previously DIS) she will be able to point me in the right direction - is there a timescale you require this by?

Regards

Jeanette

Jeanette Donnelly Southern Office Information Team Health & Social Care Board Tower Hill, Armagh

BT61 9DR

Tel: Personal Information redacted by the USI

Fax: Personal Information redacted by the USI

Email: Web: www.hscboard.hscni.net

----Original Message----

From: Corrigan, Diane

r ersonal information redacted by the ost

Sent: 26 August 2010 09:54 To: Donnelly, Jeanette

Subject: Re: Cystectomy information

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Jeanette

When we discussed this originally you mentioned that you only had access to 5 years data. However coded info has been collected further back than that. Do you know how we could go about getting the previous 5 years data in the same format? Does that require a formal info request to DHSS/Info Branch?

Diane

----- Original Message ----From: Donnelly, Jeanette
To: Corrigan, Diane

Personal Information redacted by the USI

Sent: Mon Aug 23 15:08:39 2010 Subject: RE: Cystectomy information

"This e-mail is covered by the disclaimer found at the end of the message."

Diane

See attached again - I have put each year onto a separate worksheet - for ease of reading as some of the years are quite small. Double checked the duplicates and where pts had diagnosis of cystitis and nothing. If you have any queries do not hesitate to contact me.

Regards Jeanette

Jeanette Donnelly Southern Office Information Team Health & Social Care Board Tower Hill, Armagh

BT61 9DR

Personal Information redacted by the USI

Personal Information redacted by the USI

Email:

Web: www.hscboard.hscni.net

----Original Message--_--

From: Corrigan, Diane

Sent: 20 August 2010 17:47 To: Donnelly, Jeanette

Subject: Re: Cystectomy information

"This e-mail is covered by the disclaimer found at the end of the message."

Thanks Jeanette.

I'll be in the office mid-morning. See you then.

Diane

---- Original Message -----

From: Donnelly, Jeanette

To: Corrigan, Diane

Sent: Fri Aug 20 17:10:53 2010

Subject: RE: Cystectomy information

"This e-mail is covered by the disclaimer found at the end of the message."

Diane

I have been looking at the CAH data - and don't see any duplicates - however I was trying to run this different ways to see if I could extract/highlight duplicates, in the original query/info I have given you I included Primary and Secondary Operation codes and wonder should I just have included Primary Operation as looking at the information this way for CAH only is extracting about 2-3 patients more per year, including the Secondary Operation code may have restricted it too much - maybe I could come up and speak to you on Monday at some stage regarding this.

I have attached this info for you to have a look at and see what you think. Hope this doesn't cause any disruptions for you.

Regards

Jeanette

Jeanette Donnelly Southern Office Information Team Health & Social Care Board Tower Hill, Armagh BT61 9DR

Tel: Personal Information redacted by the USI

Personal Information redacted by the USI

Email:
Web: www.hscboard.hscni.net

----Original Message-----

From: Corrigan, Diane

Sent: 20 August 2010 14:34 To: Donnelly, Jeanette

Subject: Cystectomy information

"This e-mail is covered by the disclaimer found at the end of the message."

Jeanette

I was wondering if there is any possibility that the higher proportion of cases with a diagnosis of cystitis at CAH is because of poor coding (ie patients who had the operation in the past admitted with an infection (though since they no longer have a bladder technically it should not be termed 'cystitis').

Is there any way that you are able to check patient numbers or date of birth just to confirm there are no duplicates in the CAH subset?

Diane

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Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10 Notes - Primary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2

WIT-618	5	6
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Fiscal Year	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Elective FCI
	Altnagelvin Hospital	Mulholland C.K Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Matignant Neopleam Of Bladder Unspecified	1
	energy termin	Mulholland C.K Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	C66.X	Malignant Neoplasm Of Ureter	1
	Altnagelvin Hospital						2
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Disgnostic Description	Elective FCI
	Belfast Cay Hospital	Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectumy Nec	C67.9	Matignari Neoplasm Of Stadder Unspecified	
		Hegen C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	C66.X	Malignani Neoplassii Of Ureter	1
		Hagan C Mr	M34 3	Total Excision Of Bladder - Cystrectomy Nec	C67.9	Matignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34 3	Total Excision Of Bladder - Cystectomy Nec	C67.9	Matignant Neoplasm Of Bladder Unspecified	. 1
		Hagan C Mr	M34.3	Total Excision Of Stadder - Cystectomy Nec	C67 9	Matignant Neoplasm Of Bladder Unspecified	1
		Keene PF Mr	M19.2	Urinary Diversion - Creation Of Univery Diversion To Intestine Nec	T83.0	Mechanical Complication Of Urinary (Indwelling) Catheter	1
		Hagan C Mr	M34.3	Total Excision Of Stadder - Custertimy Nec	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Walsh IK Mr	M19.2	Urinary Diversion - Creation Of University Diversion To Intestine Nec	C56.X	Malignani Neopiasm Of Ovary	1
		Hagan C Mr	M19.1	Urinary Diversion - Construction Of Beal Conduit	C67 9	Malignant Neopiusm Of Bladder, Unspecified	1
		Hagen C Mr	M34.3	Total Excision Of Bladder - Cystectory Nec	C87 9	Malignant Neoplasm Of Bladder, Urapecified	1
	The Head	Keene PF Mr	M34 1	Total Excision Of Bladder - Cyatoprostatectomy	C67 9	Matignant Neoplasm Of Bladder, Unspecified	1
		Dobbs SP Dr	M34.3	Total Excision Of Bladder - Cystectory Nec	N83.2	Other And Unspecified Overran Cysts	1
		Hegan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Matignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystersony Nec	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - C yesoprostatectomy	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cyaloprostatectomy	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
FY2005/2006		Keane PF Mr	M34,3	Total Excision Of Bladder - Cystectony Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	C67 9	Malgnant Neoplesm Of Bladder Unspecified	1
		Hagen C Mr	M34.1	Total Excision Of Bladder - Cystoprodatectomy	C87 9	Malignant Neoples in Of Bladder, Unspecified	1
		Welsh K Mr	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	N31.9	Neuromuscular Dysfunction Of Bladder, Unspecified	1
		Rajen TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 @	Malignant Neoplasm Of Bladder Unspecified	1
	Belfast City Hospital					- A - A - A - A - A - A - A - A - A - A	21
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Elective FC
	Causeway Hospital	Kemohan R M Mr	M34.3	Total Excision Of Bladder - Cyclectorn, Nec	N30 9	Cystin, Unspecified	1
	Causeway Hospital						1
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Elective FCI
	Craigavon Area Hospital	Young M Mr	M19.2	Unnary Diversion - Creation Of Unitary Diversion To Intestme Nec	N30 1	Interstitial Cystein (Chronic)	1
		O'Brien A Mr	M19.2	Unnary Diversion - Creation Of Unnary Diversion To Intestine Nec	N13.3	Other And Unspecified Hydronephrosis	1
	70 10 10	Young M Mr	M19.1	Urina Diversion - Construction Of Ileal Conduit	N30 1	Interstitial Cytistis (Chronic:	1
		Young M Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cyslertomy Nec	N30.2	Other Chronic Cystiles	1
	Craigavon Area Hospital						5
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primery Diagnosis	Diagnostic Description	Elective FCI
	Mater Hospital Has Trust	Wilson BG Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Malignant Neoplaam Of Bladder, Umspecified	1
	Transport Transport	Wilson BG Mr	M19.1	Urinary Diversion - Construction Of Iteal Conduit	N31.9	Neuromuscular Dyshmeton Of Bladder Unspecified	1
		Wilson BG Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	C61.X	Maligrant Nacplasm Of Prostate	
	Mater Hospital Has Trust	TTROUT BO MI	munt I	Lowi Pyrisinii At Disosai + Chinotomesciciui	C01.A	managraph repopulation of Prostate	3
FY2005/2006		+	+	+	+	+	32



Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10 Notes - Primary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2

PERCEI TODA	Incepital Ossenption	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Electron F
	Attragative Hospital	Mulholland C K Mr	M19.1	Unitary Diversion - Construction Of Ileal Conduit	C66 X	Malignani Nicopiasm Of Ureter	- T
		Mulholland C.K.Mr	M34.1	Total Excision Of Bladder - Cystoproviatectomy	C67 9	Marignant Neoglasm Of Bladder Lintgerried	1
		Mulholland C.K Mr	M34 2	Total Excision Of Bladder - Cystour ethrectomy	C67 2	Maignam Neoplasm Of Lateral Walf Of Bladder	1
	Altnagelvin Hospital						3
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Elettive
	Belfast City Hospital	Walsh IK Mr	M19.1	Urinary Diversion - Construction Of Ileal Conduit	Q60 0	Renal Agenes S Unilateral	,
		Keane PF Mr	M19.1	Urinally Diversion - Construction Of Real Conduit	N32 8	Other Specified Disorders Of Bladder	1
		Keane PF Mr	M34 2	Total Excision Of Bladder - Cysicus ethrectomy	C67.9	Malignant Neoplasm Of Bladder, Unapecified	,
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cytien army Nec	Ç67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cyalactomy Nec	C67.9	Malignant Neoplasm Of Bladder Unspeched	1
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cyrropi astatectomy	C67.9	Melignani Neoplasm Of Bladder Unspecified	1
		Reject TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C66 X	Margnant Neoplasm Of Ureter	- 3
		Region TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rayan TN Mr	M34.1	Yotal Excision Of Bledder - Cystoprostatic tomy	C67.9	Malignatil Nauplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cyttle Tomy Nec	C67.9	Malignant Neoplesm Of Bladder, Unspecified	- 1
		Rayen TN Mr	M34.1	Total Excision Of Bladder - Cystoprostalactomy	C67.9	Malignant Naciplasm Of Bladder Unspected	1
		Keane PF Mr	M19.1	Ulmary Diversion - Construction Of fleet Conduit	C67 9	Mass nant Nicos asm Of Bladder, Universities	
		Rejan TN Mr	M34 1	Total Excision Of Bladder - Cystoprostal ectomy	C67.9	Malignant News asm Of Bladder, United And	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cytileprostatectomy	C67 9	Mangnam Neoplasm Of Bladder, Unspecified	1
		Keena PF Mr	M34.1	Total Excision Of Bladder Cyslep of tectomy	C67 9	Mehgnent Neoplesm Of Bladder Unspecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cyslectomy Nec	C67 II	Malignam Neoplasm Of Bladder Linsperified	1
		Keene PF Mr	M34.1	Total Excision Of Bladder - Cyptoprostatectionsy	C67 B	Malignant Neoplasm Of Bladder Unapecified	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystatiomy Nec	C67 II	Malignant Neoples Of Bladder, Urspecfied	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprestated omy	C67 9	Malignant Neoples Of Bladder Linspecified	1
		Re an TN Mr	M34.1	Total Excision Of Bladder - Cystoprostalectomy	C67 9	Malgnant Neoglass Of Bladder Unspecified	1
FY2006/2007		Keene PF Mr	M34.3	Total Excision Of Bladder - Cystectumy Nec	C67 9	Malignant Veograsm Of Bladder, Unspecified	1
		Raan TN Mr	M34.1	Total Excision Of Bladder - Crassic of a sectom	C67.9	Malignant Neoglasm Of Bladder, Unspecified	1
		Keene PF Mr	M19.2	Unitedly Diversion - Creation Of Unitedly Diversion To Intestine Nec	R39 8	Other And Unspect Symptoms And Signs Involv Univery Sys.	1
		Keene PF Mr	M34.1	Total Excision Of Bladder - Cyslopi oslatectomy	C67 9	Meliginant Neuplasm Of Bladder, Unapported	
	Belfast City Hospital						23
	Hospital Description	Consultant Name	Primary Operation	Operation Description	Primary Diagnosis	Diagnostic Description	Blacker F
	Children'S Hospital	Bailie AG Mr	M34.9	Yotal Excision Of Bladder - Unspecified	C67.9	Malignert Neophism Of Bladder, Unapached	1
	Children'S Hospital						1
	Hospital Bescription	Consultent Name	Primary Operation	Operation Description	Primary Diagnosis	Disgreelle Description	Elective F
	Crisigavon Area Hospital	Young M Mr	M34 1	Total Excision Of Bladder - Cystem ostalectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cyslactomy Nec	N30 1	Interstitial Cystics Chronic	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	N12 X	Tubulo-Interstitial Maphy In: Not Episc As Acute Or Chronic	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	N30 1	Interstitial Cynitis Chronic	1
					4		
		Young M Mr	M34.1	Total Excision Of Bladder - Cyslegeosta tectomy	C67.9		
		Young M Mr O'Brien A Mr	M34.1 M34.3	Yotal Excision Of Bladder - Carlege a tectomy Total Excision Of Bladder - Carlegeony Nec	1	Mainant Hassasm Of Bladder Linguista	
				Total Excision Of Bladder - Cystlectomy Nec	C67.9 C67.9	Margham Neoplasm Of Bladder Uropecified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Simple Cystectomy	C67.9 N30 2	Maigram Micciasm Of Bledder Unspeched Other Chronic Cystin	
		O'Brien A Mr O'Brien A Mr	M34.3 M34.4	Total Excisson Of Bladder - Cystectomy Nec Total Excisson Of Bladder - Simple Cystectomy Total Excisson Of Bladder - Cystectomy Nec	C67.9 N30.2 C67.9	Maignani Neopasm Of Bladder Unspecified Other Chronic Cyslinia Malignani Neopasm Of Bladder, Unspecified	- 1
		O'Brien A Mr O'Brien A Mr Balsione GRD Mr	M34 3 M34 4 M34.3	Total Excission Of Bladder - Cystlectomy Nec Total Excission Of Bladder - Simple Cystlectomy Total Excission Of Bladder - Cystlectomy Nec Total Excission Of Bladder - Cystlectomy Nec	C67.9 N30.2 C67.9 C67.9	Malignan Macquism Of Bladder Unspecified Other Chronic Cystillia Malignan Neoplasm Of Bladder Unspecified Malignan Neoplasm Of Bladder Unspecified	
		O'Brien A Mr O'Brien A Mr Balsione GRD Mr O'Brien A Mr	M34.3 M34.4 M34.3 M34.1	Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Simple Cystectomy Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Cystectomy on the Cystection of Bladder - Cystectomy Total Excision Of Bladder - Cystect ostalectomy	C67.9 N30.2 C67.9 C67.9	Malgram Nacquest Of Bladder Unspecified Other Chronic Cystill Malgram Nacquest Of Bladder Unspecified Malgram Nacquest Of Bladder Unspecified Malgram Nacquest Of Bladder Unspecified	1 1
	Craigavon Area Hospital	O'Brien A Mr O'Brien A Mr Balsione GRD Mr O'Brien A Mr	M34 3 M34 4 M34.3 M34.1	Total Excission Of Bladder - Cystlectomy Nec Total Excission Of Bladder - Simple Cystlectomy Total Excission Of Bladder - Cystlectomy Nec Total Excission Of Bladder - Cystlectomy Nec	C67.9 N30.2 C67.9 C67.9	Malignan Macquism Of Bladder Unspecified Other Chronic Cystillia Malignan Neoplasm Of Bladder Unspecified Malignan Neoplasm Of Bladder Unspecified	
	Crail gavon Aree Hospital	O'Brien A Mr O'Brien A Mr Belsione GRD Mr O'Brien A Mr O'Brien A Mr Belsione GRD Mr	M34.3 M34.4 M34.3 M34.1 M34.1 M34.3	Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Cystectomy Strategic omy Total Excision Of Bladder - Cystectomy Ostalectomy Total Excision Of Bladder - Cystectomy Nec	C67.9 N30.2 C67.9 C67.9 C67.9	Maignant Neoplasm Of Bladder Unspecified Other Chronic Cystilla Malignant Neoplasm Of Bladder Unspecified	1 1 1 11
	Hospital Description	O'Brien A Mr O'Brien A Mr Belsione GRD Mr O'Brien A Mr O'Brien A Mr Belsione GRD Mr	M34 3 M34 4 M34 3 M34 1 M34 1 M34 3	Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Strings Cystectomy Total Excision Of Bladder - Cystectomy Nec Total Excision Of Bladder - Cystectomy strand-tomy Total Excision Of Bladder - Cystectomy Ostalectomy Total Excision Of Bladder - Cystectomy Nec	C67 9 N30 2 C67 9 C67 9 C67 9	Maignant Neoplasm Of Bladder Unspecified Other Chronic Cystifia Malignant Neoplasm Of Bladder Unspecified Official Chronic Cystific Conditions Official Chronic Cystific Cystific Cystified Official Chronic Cystified	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	PERSONAL PROPERTY AND ADDRESS OF THE PERSON NAMED AND ADDRESS	O'Brien A Mr O'Brien A Mr Belsione GRD Mr O'Brien A Mr O'Brien A Mr Belsione GRD Mr Wilson BG Mr	M34 3 M34 4 M34 3 M34 1 M34 1 M34 3	Total Excision Of Bladder - Cystectomy Nec Control Excision Of Bladder - Cystectomy Nec	C67 9 N30 2 C67 9 C67 9 C67 9 C67 9	Maignant Neoplasm Of Bladder Unspecified Other Chronic Cystell Malignant Neoplasm Of Bladder Unspecified Others of the Country Malignant Neoplasm Of Bladder Unspecified	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Hospital Description	O'Brien A Mr O'Brien A Mr Balstone GRD Mr O'Brien A Mr O'Brien A Mr D'Brien A Mr Balstone GRD Mr Wilson BG Mr Wilson BG Mr	M34 3 M34 4 M34.3 M34 1 M34 1 M34.3 Primary Operation M19 1	Total Excision Of Bladder - Cystectomy Nec Cystec	C67 9 N30 2 C67 9	Maignant Neoplasm Of Bladder Unspecified Other Chronic Cystella Malignant Neoplasm Of Bladder Unspecified Of pools of Performance of Bladder Unspecified Malignant Neoplasm Of Bladder Unspecified Malignant Neoplasm Of Bladder Unspecified	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Hospital Description	O'Brien A Mr O'Brien A Mr Belsione GRD Mr O'Brien A Mr O'Brien A Mr Belsione GRD Mr Wilson BG Mr	M34 3 M34 4 M34 3 M34 1 M34 1 M34 3	Total Excision Of Bladder - Cystectomy Nec Control Excision Of Bladder - Cystectomy Nec	C67 9 N30 2 C67 9 C67 9 C67 9 C67 9	Maignant Neoplasm Of Bladder Unspecified Other Chronic Cystell Malignant Neoplasm Of Bladder Unspecified Others of the Country Malignant Neoplasm Of Bladder Unspecified	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10 Notes - Primary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2

Claral Year	Constitution of the Consti	Control of Control of Control	CONTRACTOR AND ADDRESS OF THE PARTY.	HOI GOODS GOOD INGT. 1, MIGH. 2, MIGH.	s, elementario de consciono	Constitution of the Consti	Partition.
The state of the s	Hospital Description	_		Operation Description		Diagnostic Description	Elective F
	Belfast City Hospital	Keane PF Mr	M34 1	Total Excision Of Bladder - Cyslogrostalectomy	C87 9	Marignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bledder - Cystogrostatectomy	C61 X	Melignant Neopleam Of Prostate	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystestomy Nec	C67 g	Melignant Neopteam Of Bladder, Unspecified	1
		Hagan C Mr	M19.1	Urinary Diversion - Construction Of fleet Conduit	N30.1	Interstrial Cystria (Chronic)	1
		Walsh IK Mr	M19.1	Uninary Diversion - Construction Of Ileaf Conduit	A41 9	Septicaemia, Unapec/fed	1
		Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	J	Rainn TN Mr	M19.1	Uninary Diversion - Construction Of fleat Conduit	C53.9	Malignant Neoplasm Of Cervix Uteri, Unap	1
		Keene PF Mr	M34.9	Total Excision Of Bladder - Unspecified	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34 9	Total Excision Of Bladder - Unspecified	C67.9	Malignant Neopleam Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cyalinctomy Nec	D09 0	Carcinoma in Situ Of Bladder	1
			M34.1	for control and the second of	1000		_
		Rajan TN Mr	-	Total Excision Of Bladder - Cyalogiostatectomy	D87.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rayan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	D09.0	Carcinoma in Situ Of Bladder	1
		Hagan C Mr	M34.3	Total Excision Of Bladder - Cystrictomy Nec	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
	-	Hagan C Mr	M34.1	Total Excision Of Bladder - Cystoprostalactomy	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagain C Mr	M34.3	Total Excision Of Bladder - Cyanactomy Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
	27.30	Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Malignant Neoplasm Of Stadder, Unspecified	1
		Raan TN Mr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keans PF Mr	M34.1	Total Excision Of Bladder - Cysto rostatectom	C61.X	Malignent Neoplesm Of Prostate	1
		Rayan TN Mr	M34.1		D09.0		1
				Total Excision Of Bladder - Cyaloprostatestomy	1	Carcinome In Situ Of Stadder	_
		Keane PF Mr	M34.1	Total Excision Of Bladder - Cyatoprostatectomy	C67.9	Malignant Neopleum Of Stadder, Unspecified	1
		Rujan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectemy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	N32.8	Other Specified Disorders Of Bladder	1
		Keans PF Mr	M19.1	Urinary Diversion - Construction Of Iteal Conduit	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Keane PF Mr	M19.1	Uninary Diversion - Construction Of Iteal Conduit	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Hagan C Mr	M19.2	Urinary Diversion - Creation Of Urinary Diversion To Intestine Nec	C67 9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cysroprostatectomy	C61.X	Malignant Neoplasm Of Prostate	1
		Rayer TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67 9	Malignant Neopleam Of Bladder, Unspecified	1
		Rajan TN Mr	M19.1	Urinary Diversion - Construction Of Itsel Conduit	C67.9		1
2007/2008	1		M34.1			Malignant Neopisam Of Bladder, Unspecified	+
		Keane PF Mr		Total Excision Of Bladder - Cystogrostatestomy	C67.9	Malignant Neopleam Of Stadder, Unspecified	1
		Walsh IK Mr	M34.3	Total Excision Of Bladder - Cystectomy Nec	Q64 1	Exstrophy Of Uninery Bladder	1
		Welsh IK Mr	M19.2	Uninary Diversion - Creation Of Urinary Diversion To Intestine Nec	R32.X	Unspecified Urinary Incontinence	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Melignant Neopleam Of Bladder, Unspecified	1
		Rajan TN Mr	M34.2	Total Excision Of Stadder - Cystpurethrectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr	M34.3	Total Excision Of Bladder - Cyntrictomy Nec	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
		Rajan TN Mr.	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	t
	Belfast City Hospital		7				3.6
	Hospital Description	Consulters Name	Primary Consulton	Operation Description	Primary Otanousk	Diagnostic Description	Elective
		Marshall DF Mr	M19.2		N31 9		-
	Children'S Hospital	Maranan UT wa	M 19.2	Unitary Diversion - Creation Of Unitary Diversion To Intestine Nec	M21.8	Neuromuscular Dysfunction Of Bledder, Unspecified	+ ;
	White the same of the same				THE RESERVE THE PERSON NAMED IN		1
	Hospital Description			Operation Description		Diagnostic Description	Elective
	Craigavon Area Hospital	O'Brien A Mr	M34.3	Total Excision Of Stadder - Cystactomy Nec	R15.X	Faecal Incontinence	- 1
		O'Brien A Mr	M19.2	Uninary Diversion - Creation Of Uninary Diversion To Intestine Nec	N39.0	Uninery Trect Infection, Site Not Specified	1
		O'Brien A Mr	M34.3	Total Excision Of Bladder - Cymretomy Nec	C67.9	Malignant Neoplasm Of Bladder, Unaper fied	
		Young M Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	
		Young M Mr	M34.3	Total Excision Of Stadder - Cystactomy Nec	D41 4	Neoplasm Uncert / Unkn Behav Bladder	1
		O'Brien A Mr	M34.1	Total Excision Of Stadder - Cysloprostatectomy	C67.9	Matignant Neoplasm Of Bladder, Unspecified	
		Young M Mr.	M34.1	Total Excision Of Bladder - Cyaloprostatectomy	C67 9		
					-	Malignant Neoplasm Of Bladder, Unspecified	1
			M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neograsm Of Bladder, Unapeched	+ '
		Mcallister C Dr	M34 1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neograsm Of Bladder Unapached	1
		Young M Mr	M34 1	Total Excision Of Bladder - Cystactomy Nec	C67.9	Malignant Neoglasm Of Bladder, Unspecified	
	1	O'Brien A Mr	M34.1	Total Excision Of Bladder - Cystoprostatectomy	C67.9	Malignant Neoplasm Of Bladder, Unspecified	1
							11
	Craigavon Area Hospital		Proposition and the second	Operation Description	Primary Diagnosis	Diagnostic Description	Elective
	Craigavon Area Hospital Hospital Description	Consultant Name	Primary Operation				1
	Hospital Description				C67.9	Malignant Neoglasm Of Bladder Unapacified	
	CONTRACTOR OF THE PERSON NAMED IN	Wilson BG Mr	M34.1	Total Excision Of Bradder - Cysloprostatectomy	C67.9	Malignani Neoglasm Of Bladder, Unspecified	
	Hospital Description	Wilson BG Mr Wilson BG Mr	M34.1 M19.1	Total Excision Of Bladder - Cysloprostatectomy Uninary Diversion - Construction Of Real Conduit	C67.9	Malignana Neoglasm Of Bladder, Unspecified	
	Hospital Description Mater Hospital Has Trust	Wilson BG Mr	M34.1	Total Excision Of Bradder - Cysloprostatectomy	+		-:
2007/2008	Hospital Description Mater Hospital Has Trust Mater Hospital Has Trust	Wilson BG Mr Wilson BG Mr	M34.1 M19.1	Total Excision Of Bladder - Cysloprostatectomy Uninary Diversion - Construction Of Real Conduit	C67.9	Malignana Neoglasm Of Bladder, Unspecified	-

Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10
Notes - Primary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2

AND RESIDENCE OF THE PARTY OF T			mauor codes used - m34.1, m34.2, m	a february and the		4000
			Oderman Dan Labora	Printer Stereets		times
	Raien 1N Mr	M34 1	Spital Excession Of Statement Consequent Assessment	C678	Beingmen hangssom Of Blerider unsurer And	0.000
	B Mr	M34.3	Total Cursion Of Sustain Control Nec	No.F	Frances and getter flammer feet transfers and the	
	Heigen G. No.	M34.9	Table 5 ecoson Of Sheather - Unique Med	City	Geogram Registers 28 Station Groups Feet	-
	N 124 6As	AR34 I	Total execut of the control of the c	ID879	Burgas Dispass Of Blacks and Arched	-
	IN M	M34.3	Total Cernino Of Sussess - Capture New	D00	in Stu Of Negdow	
	Dispose II 14	MIG I	strong Democr Contraction Of their Contra	40.0	Fitting And Administrate DI Jimany Device	
	Right TN Mr	Nt34 I	Total Eucoson (M. Bandon : Cyrospendate/lumy	C479	Miningson Hamiltonia Of Righton Company	
	Kenne PF Mr	MOA 1	Total firms Of Season Capton and Capton	10479	Nagret Ingles of Settle United by:	200
	Heger C Mr	M34.3	Total Lecture Of Section - Cycles have Nec	C=79	Margani Hagania O' Rodge Strandard	
0.0	Keene PF Sh	N/34 1	Total I coson Of Hedder - California manual man	CITA	Kangrant Hermann CE Provide	
	Raup 1NM	MM 1	Total Exercision Of Hedder Equipment accurs	GU1 A	Procisio	
	Ream 16/6k	6634 I	Total Carract Of Person - Last sport of the last			-
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	Feare Pf Mt	M34.1	Total screen of Pestine Cattler state form	GE 1.	Marganet Haspianes Of Blackton Nac's.	-
- 3	THUM	M34.1	Total I screen Of Reside - Cathon seems -	C#79	Minigrant Registers Of Bratter, strapes feet	_
	Ovegov ti Mr	M10 1	Committee Of the Contract	11 70 A	The be find any Incontruence	_
	Knopno PF Ms	Mge 1	Total xxxxxx cit (marker - Cg) tags or stracture	C479	Minigrant Sensiteum Of Bladder Linguis Red	
	Higgs C. Mr	M34 T	Total I screen Of Business Cyclings and the many	C470	Resignant Feergram Of Huntdoor (1975)	99
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	Emm 19 6h	M34 3	Total Care on the Bearing - Cymertony Nec		Bridge and Management CF (Standard Colony) and and	
	la la sa	6834.3		CHTS	Biologuest (Surgium Of Business Images Park	
			Total I scream Of Harmer - Cystac Turbs New			-
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	Rest IN Mr	M34 3	Total I scenn Of Sustain - Cytin tive Nec	D414	Personal Uncert / Unior Behav Blackter	
	Frage 10 Ak	M34 I	Total Colonia Of Switch - Carriagno-maching	C879	Figure Income Of Readon Linear And	33
		N034 I				
	Plane IN 64	5034 1	Total I scenario II femine - Cynhar y a milet	-	Respect Regions 2 Strate Strate Security	-
	Rasen 1N Mr		Total Excessor Of Section 1 (1) Section 1	C079	Subgrant Response Of Blackbur , Inglies fruit	-
-	TN Mt	M34 I	Total Excessor Of Readow - Carthan in Managers	C879	Francisco Of Bladder Street	_
2	1N.64	M34.1	Total Excessor Of Headder - Egit side refreserving	G#79	Program Neurona Of Bastier (Projective)	
	Ragne PF Na	M34.2	Total enson Of Perform - gifted only Nex	DE79	Rangout Response Of Pleasure (Inglish And	
	Haper Strike	NO11	Table Excess Of Building - Egyptomorphisms	0171	Minigent Hegiser (Vijbette No.)	
	Francisco Try 644	MOM 1		U479		
-			Total Euroson Of Budder - Cathor scraft-many	-	Norgan Ingian Of States Journ And	-
	From 10 Ma	M34.1	Talah Ermon Griffmation - Cycles of Hermony	C#79	Mengrant Nangaran Of Header	_
-	Keene PF Mt	M34.1	Total stream Of human - Egypter status and	Di 79	Religions Despises Of Blakke, Linconsten	-
	Rigger TN Mr	M3rl 1	Total Extracon Of Hedder - Company outside them.	FGE79	Program Registers Of Blacker Compacted	2
	Progres (C. Mr.	M34 II	Tytal screson (24 Neddor - giventurns for:	DE79	Range and Hangman Of Stedar Step on Aud	3
	Hagan C Mr	M34.3	Total Extractor Of Manager - Egypte Surry Nec	Exe 2.9	Management Phase service Or Blanchine Company and	a
	Proper TN No	M34.1	Total Exercise Of Resident - Cattage Smaller land	0079	Margaret Hargaret Of Bertile Union deal	
	Hages C Mr	M34 1	Total Excess CH Stedam , Cyroge minimisery	C67.9	Marganet Hauginson Of (Hashfar Januar And)	-
	Figure TN Mt	мж 1	Total Excessor Of Biadder - Expression and Total	OE79	Romanut Regions of Brotte, Union Sed	
	Restrict PF 64:	M19 1	Oversion Cominction Of line Conduit	NO 1	Interplified Cases is Chronic	
100	Reans PF No	N343	Total I crason CF Treatment Cycle Suring Nec	D#79	transport Hermann Of Redoor Life on Aud	00.00
	Page TN 64	N343	Total & screens (III (Businer - Egypterhoop Nac	DE79	Or Rindring and dead	.VI.I.
	Keane PF Ms	M34 1	Total Excessor Of Medicar Continues and Cont	lce79		(C)
				_	leagues facques Of Baccor (topic du)	-
	Keene PF Mt	M34.1	Total was on Or Bedder - Carl harmy bearing	C479	Mingrant Beagains Of Bladder Universities	-
	Reans PF Mr	N343	Total Fermion Of Busine Cypherbony No.	EN/ 9	Mangated Harpison Of Station: Straps Avr.	-
	Hagen C No	M34 3	Total Licroson Of Bladder Lightermany Nec	C479	Management Recognitions CY Readout Companished	_
	rteger G Mr	M34 6	Total scalon Of the time - Other Tare See	Cerx	Management Hamagement Of Prostation	0.00
	Reamo PE No	M107	Umman Cleanton Of James Deversion To Intestine Nec	N/D 4	Other Sale fact Living Incontinence	100
200-200	Hayan C Mr	M3H 1	Total Cursion Of Medicar - Cytego - Bartony	6679	Margaret Registers of Distance (2005) Not.	
	Reane PF No	M10 1				
			United Construction of times Construction	RELY	Uniqueted Unity Incontinuous	-
	Hegen G. Mr	MM 1	Talad Science Of Planters - Fagilier relative turns	CAT 0	Management Management CM (Blackbox, 1800) per Mani	-
	Hagen E Mr	M 16 1	Deversion - Construction Of Heat Conduit	C67.9	Mangiorit Magisters Of Mediter Uniquesting	
	Hegen G Mr	MOH 3	Total scream Of Medder - Cardenberry Nec	N30 9	Cynths Disperted	200
	Roger TN NA	Mai 3	Total F-misson Of Madder - C	C47.9	Management Name and an Of Relations of the Company	S. 1
1	Treger C No	MSc1	Tatal (-Common Of Bredom - Carrigo and decroing	C67.7		
					Managered Managered Of State State	
	Keatre PF Mr	M343	Total Leoson Of Realise - Carlemony, Nec	DF7.9	Minigrant Harginers Of Besides (Images des)	-
	Dugger II M	M34 B	Total Excresion Of Brackfor - Other Issue Issue	N11 0	Neuromuscular (gratum) on Of Blackner January Seri	-
	TN 64	M34 3	hater Carriers Of Brigger - Cyclestony Nec	C#70	Magnet Inspect Officeto, projector	
Solitani City Hospital						-
Heapty Conc. poor	Consultant Name	Primary Obel Born	Coardinat Street spition	Property Disposes	Programma Complisher	Plant
Chiles S Hopes	Femilia M	MH2	Ummany Owerson - Creation Of Linning Diversion 1: Intesting Nec	NO1 0	Neuromuscular System ion Of Blackfor Linguis Ball	10
	Proto AG Mr	MW2	Oronin Character - Common Of Groups (Sections 7) Interests Nac	N13 8	Constitue	
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Congress Anniesped	Officer AM	M36.3	Table Common Of Process - Commonly New	610 ×	Organis July Incontrance	
	O'Breen A Mr	M39.1	Umay Descript - Communities Of Iteal Contact	CH2 9	Margant Require O'Baton, Joseph Rel	
15.0	O'Brien A Mt	M34.1	Total Extraors Of Bledder + Cysseps salar screen	C#7.9	Unangered Inscription Of Bladder	2.
	O'Brian A Mr	M343	Total school Of Business I make her	N30 1	Jest au s Mind C	0 :
	Ober AM	B361	Sale Larson Of Display - Carrier october a	5679	Magnet Hegges Of Retter Crops had	-
	O'Froini A Ma	3636 T	Total Lesson Of Maddle + Carbon State Server	C679	Hallanieri Herandum (2) Bladdow (2004) Feb.	-
-1	Francis M Mr.	NGC 1	Total Excess Of Blackler - Cyssics makes many	Cel x	Watgrant Hagtann Of Prostate	
	O'Free A 44	N 10 1	Construction of Heat Conduit	C67 9	Magnet Hages Of Parks and Assess	0.0
		14343	Total extent of the transport of the contract	C079	Malagrani Recultura Of Braccon Jacque Rail	· Same
	Name of the			C07.9		
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	Young N Ma	MOLS.		C679	Mingrant Imopelies Of Breader Service (in-	-
		MSH 3	Total Tursion Of Startini - Culturally Nec	C01 9		1
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Congueron Area Hospital	O'Resen A Me	M3M 3	Total I wronon Of Readon + C			1
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Constitution of the same	O'Resen A Me	M3M 3	Total I wronon Of Readder + C			1000
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Error Houseal Error Houseal Error Houseal	Veries A Mr O'Rrien A Mr Conton O'Ds	EMMS CHIMA	Total Europea Of Residue - Cyperining - New Cyperining Chee (art of) State Commission Chee (art of) Cyperining Chee (art of) Cyperining Chee (art of) Cyperining Chee (art of)	Eric en Exploses ME I	Dissprint Contrator Company Sign. Dissprint Contrator	100
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Received from PHA on 25/10/2022. Annotated by the Urology Services Inquiry

Total Patients in NI that have had removal of bladder and/or creation of an ileal conduit - From 2005/06 - 2009/10

Notes - Primary Operation Codes Used - M34.1, M34.2, M34.4, M34.8, M34.9, M19.1, M19.2

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Source: PAS DSS Admission & Discharges Universe Produced by: Information Services SO HSCB Ref: Q1025 - Run Date: 23/05/10

Diane Corrigan

From:

Donnelly, Jeanette

Sent:

20 August 2010 17:11

To:

Corrigan, Diane

Subject:

RE: Cystectomy information

Attachments:

Q1026cah pts only.xlsx

"This e-mail is covered by the disclaimer found at the end of the message."

Diane

I have been looking at the CAH data - and don't see any duplicates - however I was trying to run this different ways to see if I could extract/highlight duplicates, in the original query/info I have given you I included Primary and Secondary Operation codes and wonder should I just have included Primary Operation as looking at the information this way for CAH only is extracting about 2-3 patients more per year, including the Secondary Operation code may have restricted it too much - maybe I could come up and speak to you on Monday at some stage regarding this.

I have attached this info for you to have a look at and see what you think. Hope this doesn't cause any disruptions for you.

Regards

Jeanette

Jeanette Donnelly Southern Office Information Team Health & Social Care Board Tower Hill, Armagh

BT61 9DR

Tel: Fax:

Email:

Web: www.hscboard.hscni.net

----Original Message-----

From: Corrigan, Diane

Sent: 20 August 2010 14:34 To: Donnelly, Jeanette

Subject: Cystectomy information

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Jeanette

I was wondering if there is any possibility that the higher proportion of cases with a diagnosis of cystitis at CAH is because of poor coding (ie patients who had the operation in the past admitted with an infection (though since they no longer have a bladder technically it should not be termed 'cystitis').

Is there any way that you are able to check patient numbers or date of birth just to confirm there are no duplicates in the CAH subset?

Diane

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Diane Corrigan

From: Diane Corrigan

Sent: 23 August 2010 17:11

To: Carolyn Harper; janet.little redacted by the USI Personal Information redacted by the USI DPHM.secretary

Personal Information redacted by the USI DPHM.secretary

Subject: Confidential: Addendum to email on cystectomy figures in NI sent on 20th August Attachments: NI cystectomy andor creation of an ileal conduit as a primary procedure 200506 to

200910.xls

Dear Carolyn and Janet

The information dept ran the data again to check for duplicate patients. In doing this it was realised that the first run of information had used as a search criterion that the patients had to have had both a cystectomy AND an ileal conduit. This latest version uses EITHER cystectomy OR ileal conduit formation as primary procedure code. The latter method increases the number of patients.

The role of the regional centre seems to have become more prominent over the five year period, with cessation of these types of cases at Althagelvin and the Mater Hospitals. The specialist role in treating patients with spinal problems/neuropathic bladders is also reflected in the BCH data. There are cases where the diagnosis coding is too vague to be sure what the true underlying diagnosis might have been, e.g. for 'peritonitis, faecal incontinence, mycobacterial infection, attention to openings of urinary tract'.

In 2005/06 and 2006/07 there were 32 and 41 operations of this type respectively across NI. The number done for reasons other than malignant disease (as per the ICD coding) were 9 and 7 respectively. Four of the 9 done in 2005/06 were for cystitis of whom 3 of the four had their operation at CAH. In 2006/07 three of the seven non-malignant patients operated on in NI were coded as having a primary diagnosis of cystitis, all three of whom had their operation at CAH. This proportion might be explicable if CAH had been a centre of specialisation for this treatment, but if so that is something which was not raised as part of the Regional Urology Review.

From 2007 onwards the number of procedures done for non-malignant indications at CAH fell to 2,2 and 4. In that group of 8 cases, one was for UTI unspecified and one for mycobacterial infection but none specifically for cystitis.

On the basis of this information I am not sure that there is a clear pattern of unusually high cystectomy rates in CAH for cystitis, at least since 2007. Even so, do you think these data should be shared with the Trust? Do you think it appropriate to seek an assurance that no more radical pelvic surgery is listed for operation on that site – even though that was implicit rather than explicit in the Urology Review?

Regards

Diane



Diane Corrigan

From:

Little, Janet

Sent:

25 August 2010 15:43

To:

Corrigan, Diane

Subject:

RE: Important - advice needed on issues relating to clinical practice in Urology

Diane,

Apologies I have clearly been dealing with Emails out of sequence.

I have scanned all this and would suggest that there is enough to raise concern over the information as presented.

There is enough concern to ask the Trust for a formal report on the management of this group of patients (the requirement for central line insertion is a serious development) and it may be reasonable to suggest external input.

Happy to discuss

Janet

----Original Message----

From: Corrigan, Diane

Sent: 19 August 2010 18:24

To: Carolyn Harper; Janet.Little

Cc: Jones, Libby

Subject: Important - advice needed on issues relating to clinical practice in Urology

"This e-mail is covered by the disclaimer found at the end of the message."

Dear all

I have cut and pasted in some emails below which I hope are self-explanatory. There are also some attachments. In summary, in April 2009 I was approached by Dr P Loughran, the Medical Director of SHSCT, to seek my views as a commissioner of services as to whether a particular treatment being undertaken by Urologists in CAH was appropriate. This was regular elective admission of a small cohort of patients with chronic urinary tract infections to have IV fluids and antibiotics. The patients concerned believe that this 'flushes them out' and appear to value the treatment. I thought it was biologically implausible for this form of treatment to be any more effective than oral treatment. This view concurred with opinions Dr Loughran had already garnered from clinical colleagues. Although this treatment was wasteful of resources, it did not appear at that time to pose a clinical risk to patients. I gave Dr Loughran some advice on how to deal with the issue, including a contact for an external urology opinion.

I was next involved in January 2010 when Dr Loughran approached me to say that although he had agreed with the clinicians that the treatments

would be phased out this had not in fact happened. He had prepared a paper for the Trust's SMT and as it referred to me he sought my opinion on the wording of the relevant paragraph. I suggested amendments (which you will see below), but did not see a final version of the report. The report's Appendices (see PDF attachment) included comments from external urologists which concurred that the treatment was not in keeping with practice elsewhere in GB.

At a recent meeting with the Trust about the Urology Review it emerged that not only had the treatment not yet stopped, but some patients (possibly 2) were now receiving this treatment via a central line. Given the risk that having an indwelling line poses to patients I felt that I needed to take this further. I emailed Mr Eamon Mackle, Clinical Director of Surgery at the Trust (see below) who indicated that the Medical Director had now asked him to deal with the issue. On the day I spoke to him he did not appear to be aware that I had provided previous comments, hence the purpose of copying him information on the timeline and the draft report. I re-read the report and began to wonder if there was something unusual about the cohort of patients. One of the external opinions referenced the fact that several of the patients had ileal conduits. I imagined that the prevalent population of patients with ileal conduits in the CAH catchment would not have been very large. To put my mind at rest I asked for some information on the numbers of such operations done over the last 5 years in NI by consultant. This is attached above in an Excel spreadsheet. There are all sorts of caveats in interpreting this data, depending as it does on coding quality and completeness. However the raw data show that of 185 cases over the period, 170 had a diagnostic code which indicated malignancy or carcinoma in situ. Another 2 were coded as 'neoplasm uncertain'. Three were done by a single urologist in BCH for neurological disorders. Of the remaining 10 which did not have those diagnoses, six were done by a single consultant at CAH. Four had a primary diagnosis of cystitis, one had a diagnosis of faecal incontinence and one of peritonitis.

I have tried to think of possible data-related explanation for this. If there was very poor coding practice in a hospital then maybe a patient who had a longstanding ileal conduit, admitted for treatment of cystitis might, in theory at least, be coded as though they had the cystectomy and ileal conduit as elective operations each time - but if so that coding error would need to be highlighted and stopped. However if there really is an underlying issue - what is the role of the PHA in drawing this to the Trust's attention?

I have included draft wording of an email which I was considering sending to the Medical Director, Director of Acute Services and Clinical Director of Surgery at SHSCT. However I thought that before doing so I needed guidance on whether this was the correct way to deal with this issue.

I would be very grateful for your comments and advice on the following points

- (i) Do you agree that the line I had already taken on the use of regular IV fluids and antibiotics for chronic cystitis was correct?
- (ii) Do you agree that continuing this form of treatment in the light of

external advice from external urologists calls for further action, especially since some of patients now appear to have had central lines inserted for the purpose?

- (iii) Do you think that the statistics on cystectomy and ileal conduit creation by one consultant at CAH are sufficiently different from the pattern of treatment in other units for me to raise this with the Trust? The numbers are small and all of the information from each Trust is subject to the quality of their coding.
- (iv) Do you think my comment in the draft email seeking assurance that, following the Urology Review, no further radical pelvic surgery should now be happening in CAH is appropriate?

Regards

Diane

COPY OF EMAIL TO CLIN DIR OF SURGERY AT SHSCT

----Original Message-----From: Diane Corrigan Sent: 09 August 2010 13:12
Personal Information redacted by the US

To: 'eamon.mackle

Subject: FW: Intravenous Fluid & Antibiotic Therapy (IVT)

Importance: High

Dear Eamon

Re our discussion at the end of the Urology meeting - I found this email and thought I should forward it to you. You may by now have had sight of the Trust's full internal file on this issue.

My timeline for events relating to this issue is:

21 April 2009 - phone discussion with Dr Loughran in which he indicated that a cohort of patients having this IV treatment had come to light when implementing the Trust's new antibiotic prescribing policy. I advised involvement of the CD and if necessary external advice from Mark Fordham. I emailed Mark's address on the 22nd April.

Paddy called me again on the 4th Jan 2010 to say that although the clinicians had agreed to change practice, it had emerged that this had not happened. He planned to prepare a paper setting out the issue for discussion (? within Trust management). He forwarded a draft to me (attached) and the email below was my response. I do not think I ever saw the final report which was for internal use in the Trust. The draft paper indicated that insertion of central lines to deliver this therapy was being considered for two patients. From your comments it sounds as though this has actually gone ahead. I am very concerned as to how this could have happened. It is a matter for the Trust to decide, but I think the latter begins to sound like an SAI.

I have re-read the Appendices to the draft report. Perhaps I am reading more into them than was meant - however am I right in thinking that almost all of these patients have had cystectomy and ileal conduits for benign disease? I would have imagined this would have been a treatment of last resort. Is there any possibility that there is a wider issue here - i.e. not just the continued use of a non evidence-based treatment for UTI, but a higher than expected use of radical surgery for the underlying pathology? As a first step maybe I can ask our information department to see whether it is possible to extract information on the number of cystectomies done in NI for benign disease over the last decade. This will depend on the coding quality - however if it shows nothing untoward in terms of numbers done at CAH then concentration on IVT would remain the most pressing issue.

This could be very difficult. I would advise a team approach within the Trust - involving the Medical Director and the Dir of Acute Services - dealing with this on your own would not be a good idea.

Please let me know if there is anything else I could do.

Diane

EXTRACT OF EMAIL TO MEDICAL DIR SECRETARY

----Original Message-----From: Diane Corrigan

Sent: 06 January 2010 16:13

To: 'White, Laura'; Paddy Loughran

Cc: Wilson, Roberta

Subject: RE: Intravenous Fluid & Antibiotic Therapy (IVT)

Thank you for letting me see this draft report. I have two comments. Firstly, since I am now an employee of the PHA, I'm not sure it is technically correct to call me the 'commissioner' anymore - though the best alternative I can come up with is 'PHA adviser to the HSCB Southern office' which is very longwinded. With that in mind could I suggest that page 3 para g is amended to read

"I have discussed the above with Dr D Corrigan, the PHA adviser to the HSCB Southern office. On the basis of the information provided, she has advised that it would not be appropriate for SHSCT to continue to provide a treatment for which there is neither a published evidence base, nor a supporting consensus of professional opinion outwith the Trust. If SHSCT urologists feel strongly that this treatment is of value they should participate in a recognised clinical trial, with ethical committee approval. For those patients already on this treatment regimen an orderly process should be agreed and implemented to move them onto alternative treatment regimes, with the support of medical microbiology. It will be important that the reasoning behind this decision is sensitively communicated to this cohort of patients."

I also think the patient names should be removed from the Appendix (Carmel Hanna's letter) as the report may end up being copied and this could lead to a breach of patient confidentiality.

Regards

Diane

----Original Message-----

From: White, Laura

Sent: 05 January 2010 14:19

To: Corrigan, Diane Cc: Wilson, Roberta

Subject: Intravenous Fluid & Antibiotic Therapy (IVT)

Dr Corrigan

Enclosed as per your telephone call with Dr Loughran, you are mentioned under Page 2, No 6 and Page 3, "G".

Laura

Ms Laura White
Personal Assistant to
Dr Patrick Loughran
Medical Director
Southern Health & Social Care Trust

DRAFT EMAIL TO SHSCT 19 AUG 2010 VERSION

Dear

In the context of the Urology Review implementation process, which highlighted a high proportion of elective urology episodes which did not have an operative procedure, I re-read the external expert reports relating to the use of IV therapies at CAH (Appendices of the draft document I was asked to comment on last January). I picked up on a comment that many of the cases had ileal conduits. I emailed Eamon Mackle a few weeks ago to the effect that just to put my mind at rest! intended to seek NI-wide information on the numbers of cystectomies and ileal conduits carried out by Unit and consultant.

I enclose the results. These have to be interpreted with caution as they are dependent on coding quality. In addition I appreciate that the numbers are very small. It appears that cystectomy and conduit creation is done in the great majority of cases for malignant disease. However there appear to be small numbers done for other reasons. Four of the operations coded as being done by one of the CAH surgeons were for

cystitis. This would appear to be unusual. Is there any possibility that this reflects incorrect coding and in fact these are multiple admissions of patients who have had the procedure in the past and who have been admitted for other reasons?

Following the Urology Review decision, as of March 2010 radical pelvic urology surgery for malignant disease should no longer be being done in SHSCT. This would include cystectomy. We have discussed the cancer cases recently at the meeting chaired by Beth Malloy from PMSI at the HSCB. The rationale for this policy decision, which is in line with IOG guidance, was to concentrate the relatively small number of such cases in the hands of a small number of surgeons who could maintain specialist sklills. No reference was made in the Urology Review to radical pelvic surgery for non-malignant disease. It was perhaps assumed to be implicit that the even smaller volume of this type of work would also be centralised. I would be grateful for an assurance that the urology team is now referring on all patients being considered for radical pelvic surgery regardless of the underlying diagnosis.

Best wishes

Information Act 2000.."

Diane

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